King County Public Health
Operational Master Plan

Funding Issue Paper

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Submitted by
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Please note: This background paper should be viewed as a dynamic product. It is likely that new information will continue to be provided during the life of this project. The reader should regard this paper together with the companion papers on Role Definition, Policy Environment and Health Environment as initial guidance for the production of a broad policy framework.

Executive Summary and Implications for Next Steps

In this executive summary we provide our interpretation of the significance and meaning of the observations in this paper as they relate to a broad policy framework for public health in King County. First, the key observations:

- **Funding approaches for PHSKC are fairly typical of CMHD.** While PHSKC has significantly higher per capita funding overall than CMHD, the department is funded in a similar fashion with many of the same sources of funding as the CMHD interviewed.

- **Local funding for PHSKC is low.** Local general fund support is higher among four of the five CMHD, both as a percent of budget and on a per capita basis. The level of local funding for PHSKC is significantly lower than that for comparable health departments. This lack limits flexibility in making decisions about what services to conduct, and limits the health department's ability to develop capacities for core responsibilities.

- **State support of local public health is low:** Total funding from the state to PHSKC in 2005 provided $16.33 per capita. When one considers all sources of funding for public health (more broadly defined and inclusive of all federal, state and local funding), a yearly survey by the United Health Foundation shows Washington State to be 44th in the nation with total per capita support of $81.

- **Adequate discretionary funding is essential.** Most of the funding streams, and particularly federal categorical programs, available to local health departments offer limited opportunity to build capacities for services that are core to the mission of public health. Flexible funding sources are of critical importance to assuring capacities to conduct community assessments, perform communicable disease control work, and conduct population-level work designed to improve overall health status.

- **Core capacities have been assembled creatively with categorical funding.** In the absence of adequate levels of discretionary funding, virtually all health departments assemble capacities for assessment, community participation, and other core activities from creative use of categorical program funds. Those capacities are continually at risk of funding shifts among the categorical programs.

- **Public Health Funding is not predictable.** All MMHDs in the country are facing the same challenges with regard to funding. It is not possible to predict with certainty the likelihood for expansion or contraction of existing public health funding streams in the current political environment.

- **Funding opportunities don't have equal merit.** Adding more categorical programs may not really strengthen health department core capacity and may be a distraction in some instances. It can also lead to a dilution of managerial resources needed to support the department's mission.

- **PHSKC has managed well through lean budget times.** However, it is very important to understand that the nearly flat budget over the past 5 or 6 years is taking its toll. Costs increase by perhaps 5% per year while revenues at the macro level have increased less than 3% per year. It will not be possible to maintain services at current levels without new resources.

Important implications for next steps in development of the policy framework based on this description of funding include:

- **Being clear on mission and core responsibilities is essential, particularly in times of uncertain funding.** There is no agreed upon definition of "core" and it is more a term of art subject to various interpretations. In order for the funding challenges of today and tomorrow to be addressed adequately, the core responsibilities need to be defined on a basis of the Departments mission and vision, and should be the basis for programmatic decisions in the future.

- **PHSKC needs higher levels of discretionary funding.** With the relatively large dependence of PHSKC on external funding sources, it should not be a surprise that activities and services are heavily influenced by the Federal and State politics and policy. In order to assure a well functioning and effective local public health system, adequate levels of flexible funding, including in particular adequate local funding, is critically important to creating a public health infrastructure able to protect and improve the health of the community.

- **Stability of external funding for the years ahead is dependent on numerous issues.** While federal and state funding is dependent to a significant degree on the changing make-up and political perspectives of members of the respective legislative bodies, some generalities can be stated and might be considered as implications for future choices and for the policy framework:

    - Federal categorical programs with well-established successes and large, supportive interest groups have fared reasonably well in the past during economic downturns. Examples include Immunizations, WIC, and probably HIV/AIDS programs (although the latter is currently experiencing budget challenges).

    - Programs with less well-established successes and/or with political "liabilities" are challenged in Congress each year. Examples include health workforce programs, family planning, community block grant funds.

    - Funding associated with building critical basic infrastructure to assure minimal levels of essential services, for example epidemiology and surveillance, have been tied to categorical programs like Bioterrorism and Pandemic Flu preparedness. The CDC made early attempts to promote "dual use" strategies; however this emphasis has disappeared in recent grant cycles.

    - Large programs that have appeared "over night" in recent years are probably at risk of disappearing or going through significant down-sizing. An example is the bioterrorism preparedness program.

    - Most stable and subject to the most growth potential at present are funds generated by dedicated tax assessments (e.g. Alameda County; as growth continues, the revenues will continue to grow).

- **Primary care needs are not declining.** Unless a major health access initiative occurs at the state or federal level, health departments providing primary care will continue to see increases in the numbers of un- and under-insured people. Costs will continue to rise, while Medicaid and Medicare reimbursements are declining, at least at present.

- **Innovative approaches should be considered.** Some of the answer to longer term stability may lie in completely reassessing the costs and benefits of the funding streams currently in play for public health, and

considering an approach similar to that being attempted in Alameda County, CA. There, the director believes the only hope for making significant gains in health status and decreases in health inequities is through full engagement of the community, addressing the social determinants of health.

Introduction

Purpose of this paper

In this paper we provide a high level overview of the funding for public health in King County. The paper is meant to complement three other related papers dealing with the role of public health, the health environment and the policy environment. The focus of this paper is on public health funding sources, funding stability, and how PHSKC compares with comparable metropolitan health departments (CMHD) regarding funding and budgets. Because of the overarching nature of each of the four themes, some of the issues addressed in the other three papers will be touched on in this paper as well.

This White Paper is written as a part of Deliverable A, Phase I Framework Development for the Public Health Operational Master Plan for Public Health Seattle-King County. The paper is intended to address funding issues for public health. The specific language of the project RFP requested the following content:

What is the forecasted funding under the current funding streams? Include:

a. Most common funding approaches for MMHDs and how they provide short, mid and long term stability compared and contrasted to those for PHSKC. *(include a description of the federal to state funding ratios as well as how funding breaks down along the lines of core discretionary and categorical)*
b. Forecast the risk for PHSKC's various funding streams, separating by discretionary source vs. categorical source for the next 10 years, establishing risk levels for stability and corresponding expenditure/programming that is most vulnerable as well as providing assessment of funding sources for the future. (Due to the conclusion that public health funding is not predictable, (see executive summary page 4), Milne & Associates was not able to detail forecast the revenue streams for the next 10 years. Milne & Associates did provide a risk assessment of the revenue streams and drivers that may impact their continuation.)

The RFP was issued subsequent to the County Council budget proviso adopted as part of the County's 2003 budget. This background paper goes beyond the

specific information requested, giving consideration to budget issues identified from stakeholder interviews and review of PHSKC budget documents and related information.

Terminology:

Several terms have been used in this paper to describe programs or services in order to covey the degree of external influence, particularly financial, on a program. In order to address funding issues, we would recommend using the following definitions with this paper and throughout development of the Operational Master Plan. The terms are also included in the Glossary, Appendix 1.

- Discretionary — Programs, activities or funding for which authority rests solely with the department or local policy makers to address public health issues or problems. Discretionary funds are the most flexible category of resource.

- Mandatory – Explicitly required by state or local laws or regulations.

- Enhanced Mandatory – Programs and activities associated with mandatory programs, but providing services beyond basic program requirements.

- Match – Funds or other resources, usually local, which must be applied to a specific program or activity under rules associated with the granting authority for the program or activity. While these funds begin as discretionary, once a grant requiring matching funds is accepted, the match dollars are no longer discretionary but are bound by the grant contract.

- Non-discretionary —Programs, activities or funding for which authority rests with the granting organization, usually federal or state. While such programs and activities are contractual in nature, specific contract requirements may be subject to some negotiation between the Department and granting authority. All categorical funds are, by their very nature, non-discretionary.

- Recommended – Programs or activities implied or directed by State or National Standards, or commonly understood to be good public health practice. At this point in time both National and State Standards are not mandatory.

- Core – Responsibilities, programs or activities critical to the mission of public health and embodied in the intent of Essential Services, NACCHO Operational Definitions and/or State Standards.

Background:

Public health funding sources: Local health departments of all sizes rely almost exclusively on public funding and service reimbursement (including fee revenue) to support operations. The most recent national data available (NACCHO, 2001[1]) indicates that for health departments serving populations of 500,000 or more, budget sources include local tax support (36%), state funding (35%), federal funding (8%), service reimbursement (16%), and other sources (4%). Each of those funding streams is described below.

- Local Funding: The percentage of budgets from local general fund support (county and city) for local health departments varies widely, but typically is in the range of 25% to 50%. Compared with all funding streams, local funding has the greatest potential for flexible use, potentially supporting what most view as core mission activities which other available funding streams don't fund. Community assessment, community organization, system development, and convening activities rely mainly on the availability of flexible funding. To the degree that local funding is lacking (PHSKC had the lowest amount of the four county or city CMHD; the fifth is part of a state-centric system), flexibility decreases and the potential to support these core activities is less. Moreover, health departments with relatively small local support typically seek resources from a wider range of funding sources, such as direct federal or private foundation grants, as strategies to support core activities. Many of these grants are time-limited, placing additional pressure on the organization to continue the program after grant funding expires.

- State Funding: State funding decisions regarding public health vary widely in both amount and purposes supported. Most states allocate resources for local health departments, although there is very little consistency in per capita approaches and amounts. In most cases, state support is earmarked to support state public health priorities; often funding augments federal priorities (e.g. preparedness). But support for specific local community needs is typically not considered in defining state funding priorities. Funding may be transmitted to local health

[1] Local Public Health Agency Infrastructure: A Chartbook. National Association of County and City Health Officials. (October 2001)

departments by states as program funding (i.e. supporting specific programs) or as formula funding (e.g. based on population).

Well under half of the states include responsibility for local public health as a state function. In such states, local health department employees are employees of the state, most policy is generated centrally, and the state serves as a principal source of funding. Typically, very little local funding is included in health department budgets in these states. One of the CMHD (Miami-Dade County) is located in one such state.

It is nearly impossible to compare state investments in public health because of widely differing budgeting systems and differing definitions of what is included as "public health." The NACCHO database is not complete, so does not account for all state funding for public health. Efforts have been conducted to determine levels of funding for local public health in the US.[2] In each case, however, it was determined that a great deal of effort would be required to collect comparable data from all 50 states regarding public health expenditures, and comprehensive efforts were not undertaken. In an effort to compare CMHD, this report uses the National Association of County and City Health Officials (NACCHO) 2006 unpublished and self-reported profile forms, summarizing 2004 and 2005 data, submitted by the respective health departments.

The United Health Foundation provides an annual ranking of states titled "America's Health Ratings: A call to Action for People and Their Communities."[3] One of the rankings used is "Per Capita Public Health Funding." That rating differs from what is included in the NACCHO data; it includes "direct public health care," "community based services health expenditures," and "population health expenditures." The funds included in this measure are inclusive of all federal, state and local revenue sources. The 2005 data show that the average per capita public health funding was $162. Table 1, below, summarizes per capita support in Washington and in the 5 states from which the CMHD were drawn, along with their respective national rankings in that category.

Table 1
Comparison of Per Capita Public Health Funding – 6 States

State	Per Capita	Ranking
New York	$ 316	4

[2] Including "Measuring Expenditures for Personal Health Care Services Rendered by Public Health Departments" - April 1997, and Where Do the Dollars Go? Measuring Local Public Health Expenditures - March 1998 by the Public Health Foundation, Washington, D.C.
[3] http://www.unitedhealthfoundation.org/shr2005/Findings.html

Florida	143	27
California	132	29
Ohio	127	32
Tennessee	91	43
Washington	81	44

The lower level of state funding in Washington certainly reflects changes that have happened over that past ten years or so. Prior to the mid-1990s, basic local public health services were supported through local governmental general funds and little state money. While the amount of local funds provided were guided by formulas published in the WAC, the formulas were non-binding and per capita support varied widely from county to county. That approach was replaced by legislative action, substituting local tax revenues with a state-wide motor vehicle excise tax. A subsequent voter decision resulted in elimination of the MVET tax as a funding source for public health. A funding crisis in the state resulted. While the state legislature took action to mitigate 90% of the lost public health revenue from state general funds, a gap was left that has not been fixed. Turnover of legislators and legislative staffers during and since that period may well signal the loss of opportunity to repair the damage.

At present, the State of Washington contracts with local health departments to provide two streams of revenue. One, termed "state public health support", is formula based for basic public health support and the other, called "state public health direct," includes a combination of funding for specific services local health departments contract with the state to provide and replacement funding for MVET tax. Combined for King County, those two revenue streams from the state provided about $29,202,185 in 2005, or $16.33 per capita.

- Federal Funding: Federal funding decisions for public health are not made, in general, on a basis of a federal strategic health plan or clear priorities, or even on leading causes of health problems. Rather, federal allocations to public health are made principally to continue established programs, address emerging issues that are receiving attention in the media, and in response to interest group advocacy.

  Many if not most federal programs are promulgated in response to a specific disease or health condition. Federal grants directed at relatively narrow health issues are referred to as "categorical programs." Such programs include funding restrictions about client eligibility, service definition, and expenditure of grant funds. It is not uncommon for such restrictions to seriously hinder flexibility to address broader

interconnected health problems. For example, bioterrorism funding requirements limit use of the grant funds for preparedness for other public health emergencies such as avian influenza. The net effect is that many federal grants are, in effect, silos which limit health department flexibility. It has been said that categorical approaches are the most effective approaches for appropriating funding and the least effective strategies for administering programs. Many of the programs run by PHSKC and the CMHD considered in this work are categorical, including WIC, HIV/AIDS, and Bioterrorism Preparedness. Local funding and management may be able to weave/bridge these categorical programs into a more systematic and integrated strategy to overcome the seemingly "categorical" nature of these programs to meet local priorities.

Federal agencies that provide grants to local public health (usually through the states) include the Centers for Disease Control (e.g. sexually transmitted diseases, HIV/AIDS, tobacco control, local public health emergency preparedness), the Health Resources and Services Administration (e.g. community health centers grants, family planning, maternal and child health), and the US Department of Agriculture (WIC). All of the categorical programs funded by federal agencies are authorized in statute; each is controlled by a unique set of program requirements regarding client eligibility, authorized activities, reporting requirements, etc. In most instances, funding for such federal grants is administered by the states which, in turn, contract with local health departments for performance, sometimes applying additional requirements or restrictions. Some grants (e.g. community health center grants, some preparedness funding) are funded directly by a federal agency to local health departments or community organizations, bypassing the state departments of health. Local health departments receiving direct federal grants are typically large, metropolitan health departments. Directly funded grants from the federal government to PHSKC are summarized in Appendix 5.

- Service Reimbursement: This funding category includes fees collected from patients/clients of public health services, fees for permits and licenses (usually restricted to environmental health services), and reimbursements from insurance plans, Medicare and Medicaid. In this latter category, Medicaid is far and away the most significant revenue source for most local health departments.

    - Medicaid: Medicaid is a significant source of funding for many local health departments, and particularly for those providing primary care or extensive clinical services. Medicaid principally

provides payment for healthcare services, and can also be used for a designated set of administrative services. The federal Centers for Medicare and Medicaid Services (CMS), housed in the US Department of Health and Human Services, administers Medicaid through agreements with the states. Prior to the late 1980s, the federal agency defined which health services were reimbursable, and provided funding on a match basis with the states. State legislatures were given some flexibility in defining eligibility requirements and were required to match federal payments at a slightly lower percentage than the federal percentage. Provider organizations (private physicians, medical centers, health departments) submit billings for client services to the state Medicaid agency (the Department of Health and Human Services in Washington State); the agency reviews billing information and authorizes reimbursement.

The federal Medicaid agency began allowing limited experimental approaches at the state level beginning three decades ago to test completely new strategies for health care delivery and financing. Section 1115 waivers were used extensively by states interested in pursuing welfare reform in the late 1980s and early 1990s and have contributed to significant state innovation. Experiments have resulted in new managed care service delivery and financing mechanisms, and have enabled federal Medicaid funds to be used to cover expanded populations of low-income individuals who would otherwise be uninsured.

The current administration has been fairly aggressive in encouraging waivers. The administration has signaled that it will permit states to offer reduced benefit packages to certain populations and to require them to pay higher levels of cost sharing than were previously permitted under the Medicaid statute. Some analysts have raised concerns that some of the waivered approaches are not appropriate for low-income and medically fragile populations and may have negative effects on access to medical care.

Medicaid is also the source of funding for Federally Qualified Health Centers (FQHCs). FQHCs include Community Health Centers, Migrant Health Centers, Health Care for the Homeless programs, Public Housing Primary Care programs, and Urban Indian and Tribal Health Centers. Once an organization meets requirements for designation as an FQHC (e.g. non-profit

organization, community governance board, sliding fee scale), its reimbursement rate is calculated prospectively at or near actual cost of providing service. PHSKC has FQHC designation, awarded for fulfilling federal requirements in providing both primary care services and its Health Care for the Homeless program. In 2005, PHSKC received about $17.5 million through its FQHC designation.

- Other User Fees: Most local health departments, including PHSKC and the CMHD, collect fees from users of services. Some fees are for clinical services provided to patients/clients of the health department, while others are for licenses and permits granted by the health department for such activities as septic systems, food service licensure and inspection, and licensure of public swimming pools and spas. Fees are typically set by boards of health or other governing bodies on a basis of service cost. In some states, many of the environmental health fees are set by state regulation. In most states including Washington, user fees are restricted for use only within the service or activity in which they were generated.[4]

Budget Support for the Essential Services: Most MMHD agree that assuring that the Ten Essential Public Health Services are fulfilled within a local public health system is of critical importance. (The essential services have been discussed in previous background papers, and are included in two versions in Appendices 2 and 3.) Because of limitations in how revenues in the various funding streams may be used, however, health departments struggle with funding general activities that are core to the public health mission and are directly related to one or more of the essential services. While some activities (e.g. restaurant inspection) line up well with an essential service (No. 6, enforce laws and regulations), most do not. Table 2 on the next page is an attempt to illustrate comparative flexibility of funding sources, comparing the potential for various resource streams to support individual essential services. (It should be emphasized that the table was developed by Milne & Associates based on the collective experience of the project team. It is used principally for illustrative purposes.)

For health departments receiving sufficient funding from flexible revenue streams (especially local support), fulfilling the governmental public health role to assure the ten essential services is not too great a challenge. Unfortunately, many health departments do not have sufficient local or other flexible funding, and as a result gaps appear in fulfilling the essential services. Such health departments typically try to "piece together" capacities for community assessment, community organization and other core mission activities from

[4] Interview, Washington State Association of Local Public Health Officials, April, 2006.

categorical grants, leveraging some of the grant resources for "related" activities. PHSKC, for example, has found it necessary to be very creative to assemble the resources needed to conduct community assessments and to provide data to partner organizations. It is clear that flexible local funding is important to connect the categorical programs, reducing their silo effect, and to assure that the essential services are performed.

Table 2
Flexibility of Funding Sources in Supporting Essential Services
(For Illustrative Purposes Only)

Essential Service	Federal Funds	State Funding	Local Funding	Licenses & Permits	Medicaid & Medicare	Client Fees
1. Monitor health status	Medium	Low-Medium	High	Low	Low	Medium
2. Diagnose & investigate health problems	Medium	Medium	High	Medium	Low	Low
3. Inform & educate	Medium -High	Medium – High	High	Medium	Low - Medium	Medium
4. Mobilize partnerships	Low	Medium	High	Low	Low	Low
5. Develop policies & plans	Low	Low	High	Medium	Low	Low
6. Enforce laws & regulations	Low	Low – Medium	High	High	Low	Low
7. Link people to services	High	Medium	High	Low	High	High
8. Assure competent workforce	Low	Medium	High	Low	Low	Low
9. Evaluate effectiveness & quality	Low - Medium	Low – Medium	High	Low	Low	Low
10. Research for innovation	Low	Low	High	Low	Low	Low

Source: Milne & Associates, LLC

By way of example from the chart above, the potential to support health department capacity to monitor health status (Essential Service #1) is estimated to be of medium potential using federal funds, high potential with local funding, and low potential using Medicaid.

The question of how much resource is needed by health departments has never been answered satisfactorily. Washington state is perhaps in as good a position as any state to address this question, since it has in place a set of performance standards specifically designed for the well-defined system of 35 local health departments and the state department of health. This challenge

was considered by the Public Health Finance Committee for the Public Health Improvement Plan. The Committee concluded: "System-wide planning for stable funding is not possible within this current framework [of financing]." The PHIP-sponsored Public Health Standards were designed to identify an expected level of performance from the state's public health system. It was estimated that an additional $400 million is needed to meet the state standards at a 95 percent level. Research to refine that figure continues and should be published in the summer of 2006.

One limitation to use of Essential Services or the State Standards is the lack of specificity with respect to performance measures, performance expectations or outcomes. There are numerous national efforts underway to better define performance and capacity (as described in the policy paper).

Approach:

To compile the information contained in this report, Milne & Associates (M&A) reviewed a large number of documents provided by PHSKC regarding the funding of the health department, including budget information for the years 2000-2005 and the approved budget for 2006. In addition, M&A had a number of discussions with King County and PHSKC budget staff, with the Washington State Department of Health, Washington State Association of Local Public Health Officials, and others. M&A reviewed information from numerous externally produced documents, including the Public Health Improvement Plan. Questions related to the funding of public health were included in stakeholder interviews and with interviews conducted with directors and senior staff of five major metropolitan health departments (MMHDs). A draft of this paper was shared with PHOMP and PHSKC staff for their review and comment as an additional check for accuracy of information contained in the paper.

Findings:

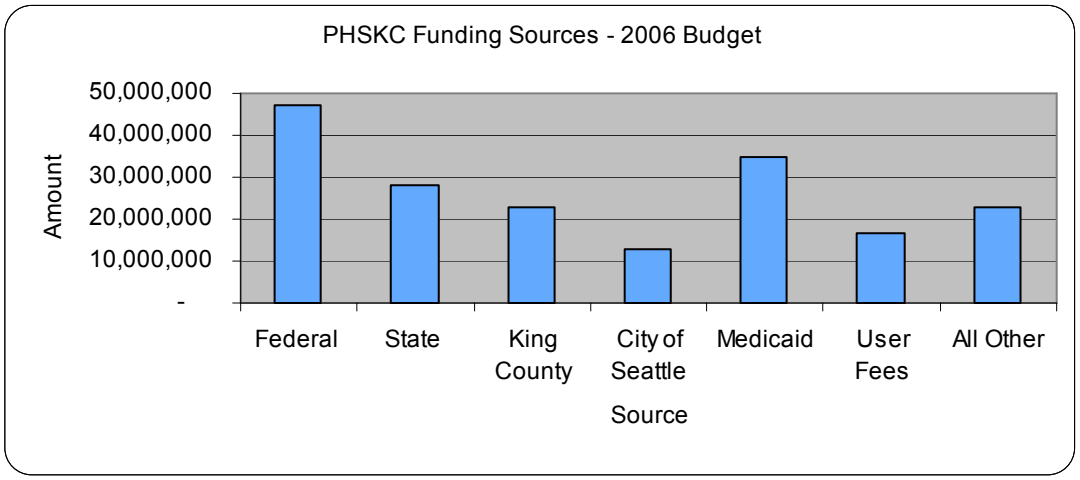
PHSKC Funding:

PHSKC has one the most complex budget structures and mix of funding sources that M&A has experienced. For purpose of this background paper we have collapsed and categorized revenues to provide a macro level view of issues and trends affecting revenues in the Public Health Pooling Fund. As discussed in later sections, this will introduce assumptions or conclusions that may not be fully accurate in reflecting impact at the program or project level. Conversely, the project level accounting which creates the complexity affords the opportunity to "fine tune" and isolate management, policy and geographic impacts more precisely.

There are 251 distinct revenue line items and 123 projects (down from 151 in 2005) in the 2006 adopted budget. In addition, revenue line items in many instances support more than one project. Since 2000, there have been 289 projects and 581 revenue line items. Some of these changes may represent changes in name only; however, it was not possible for us to provide a totally accurate trend analysis beyond one or two years.

The total budget for 2006 is $185.7 million, up 0.8% from 2005. Chart 1 compares the budget estimate of revenues by major funding source for the 2006 budget. (It should be noted that this figure does not include the Jail Health or Emergency Medical Services programs or their associated revenues. Table 4 on page 19 does include those programs, reflected in the $243.8 million budget amount.)

Chart 1
Source: PHSKC Financial Data



Federal funds make up about 25% of the budget, state funds account for 15% and local funds (King County and Seattle combined) make up 19% of revenues. Overall, the PHSKC budget has remained fairly static since 2002, with some decrease since 2003. Table 3 displays changes in funding levels by source since 2003. (Note: all figures for 2003-2005 are actual revenues.)

Table 3
Changes in Revenue from Prior Year

	2003 Actual		2004 Actual		2005 Actual		2006 Budget	
Federal	53,561,274	17.4%	57,664,291	7.7%	53,060,031	-8.0%	47,187,998	-11.1%
State	30,145,684	10.0%	28,239,213	-6.3%	29,202,185	3.4%	28,199,192	-3.4%
King County	17,135,788	-1.6%	23,062,191	34.6%	20,456,653	-11.3%	23,000,080	12.4%
City of Seattle	16,608,638	-7.4%	14,697,117	-11.5%	13,055,283	-11.2%	12,790,875	-2.0%
Medicaid/FQHC	30,744,140	5.9%	31,048,152	1.0%	36,138,458	16.4%	34,914,327	-3.4%
Other User Fees	13,434,634	16.3%	14,484,020	7.8%	15,146,360	4.6%	16,765,874	10.7%
Other	35,139,816	-4.8%	15,887,167	-54.8%	17,122,169	7.8%	22,800,173	33.2%
Total	196,769,974	5.9%	185,082,151	-5.9%	184,181,139	-0.5%	185,658,519	0.8%

Wide swings in funding levels from year to year, as can be seen from the percentage changes in the table, can create significant management challenges. The growth in Medicaid and user fees has been strong in most years, however, increasing since 2003 by 13.6% and 24.8% respectively. But overall, the total budget for 2006 is almost 6% less than it was in 2003, with funding from the following sources declining since 2003: Federal (-11.9%), State (-6.5%), All other (-35.1%), and City of Seattle (-11.9%). It is also important to note that support from the City of Seattle declined by nearly $5 million between 2001 and 2005, while support from King County has increased by about 26%.

County general fund dollars have been somewhat unsteady since 2000, decreasing in 2001, 2002, 2003, and 2005. County general funds budgeted for 2006 increased about12% over 2005 levels and are supporting 42 projects compared with 40 last year. This revenue source has increased by 23% since 2000, or 3.8% per year. It is also interesting to note that county general funds have been moved around between projects from year to year, demonstrating that PHSKC has reasonable flexibility with this revenue source. For example, for the 15 projects budgeted in 2006 for more than $250,000 in county general funds (excluding King County Overhead), 7 were increased by 20% or more over the 2005 allocation level, 2 were newly funded with county general funds (Family Health and Clinical Dental Services), and 1 was decreased by slightly over 20%. Overall, 19 of the 41 projects received allocation changes (increases and decreases combined) of 20% or more, and six programs that did not receive county general funds in 2005 are budgeted in 2006.

Two programs in particular have received significant increases in county general fund allocations since 2000, and especially over the past 2 or 3 years: the family planning project has increased its general fund allocation by 1095% since 2004 and Tuberculosis Control has seen a 224% increase. As a side note, it appears that the family planning project was supported not only by significant increases in county general funds, but also through spend-down of the fund balance. Staff indicated that a significant portion of this increase reflected need in 2006 to distribute pharmacy costs, affecting the family planning, family health and dental programs. Appendix 6 shows changes in allocation of county general funds to projects from 2000 to the 2006 budget.

County general funds comprise the most flexible revenue category that PHSKC has if viewed from the perspective of the County. As with most local governments, the funds are authorized by the legislative branch for purposes recommended by the executive branch. With the exception of general funds to be used as match for a grant, there is a high degree of potential discretion as to how these funds may be budgeted and what activities they supports. Program support from county general funds has as much to do with historical

patterns, control, politics and advocacy as it does stating the county's public health policy.

The 2006 business plan for PHSKC identifies five business lines: Population & Environmental Health; Emergency Medical Services; Targeted Community Health Services; Clinical & Primary Care Services; and Management & Business Practice. Table 4 shows the distribution of the budget into these categories.

Table 4

LINE OF BUSINESS	2006 ADOPTED	Pct.
CLINICAL HEALTH SERVICES/PRIMARY CARE ASSURANCE	41,022,430	22.1%
EMERGENCY MEDICAL SERVICES	766,596	0.4%
MANAGEMENT & BUSINESS PRACTICE	11,466,650	6.2%
POPULATION & ENVIRON HEALTH SERVICES	60,299,652	32.5%
TARGETED COMMUNITY HEALTH SERVICES	72,103,191	38.8%
TOTAL	**185,658,519**	

The issue of budget clarity came up on several occasions during the interviews, including member of the Council and the Board of Health, and was experienced by M&A in attempting to gather information for this background paper. The accounting structure, as complex as it may seem, is an excellent cost accounting structure that can be employed to analyze policy and performance. The ability to match revenues and expenditures by location, program and cost center is a valuable management and policy analysis tool if understood and utilized for that purpose. One could easily ask "why is Current Expense (or any revenue for that matter) supporting this program or activity, for this population and in this location" to get an idea of the management and policy implications. It is at this level and not the Fund level that reveals what PHSKC is doing, and what may be affected by revenue changes. However, that level of analysis has not been completed.

Most common funding approaches:

The financing of local public health departments of all sizes around the country is complex and difficult to characterize. Complicating factors include:

- wide variations in local and state general fund support
- complexity imposed by programmatic silos of categorical funding
- numerous, often convoluted formula-based allocation methods, particularly at the state level
- variations in the services provided
- the effect of multiple years of incremental decision-making

Both the Role Definition and Policy Environment background papers discussed at some length factors considered by health departments, including the CMHD, in making decisions about what programs to operate. The implications

for this paper are that the budgets for health departments will vary widely as a result. Appendix 4 summarizes factors affecting CMHD strategic decisions.

Sources of funding:

Actual revenue streams available to local health departments (and the CMHD) are consistent. What varies widely are the use of the streams and the amount of revenue provided by each. Table 5, on the next page, compares funding by revenue stream between PHSKC and the five CMHD.

It should be noted that the sources of data in Table 5 and Chart 2 on the following page, are unpublished, self-reported profile forms, summarizing 2005 data, submitted by the respective health departments to the National Association of County and City Health Officials (NACCHO) for inclusion in the 2006 Chartbook.[5]

It is not clear whether the data from each of the health departments accurately reflect audited revenue reports. It has been suggested to us, for example, that the form submitted by PHSKC was not reviewed centrally prior to its submission. At least two of the CMHD submitted the forms without keeping a copy or tracking reliability of their data. The data from Alameda County Health Department don't appear to differentiate between federal indirect support (administered by the states) and state support. Nevertheless, the data should be reasonably adequate for comparative purposes.

The comparisons in the chart reflect percentages of each funding source and are somewhat misleading since the dollar amounts vary significantly, ranging from $37.8M for Columbus to $243.7M for PHSKC. Additionally, services provided by the respective health departments vary fairly significantly as discussed in prior background papers. Furthermore, some of the funding categories are amalgamations of smaller funding streams (some of which may be unique to the state or CMHD), showing additional differences. Nevertheless, the chart helps identify a few interesting differences:

- Local Support: PHSKC receives a much smaller portion of its budget from city and county sources (15% vs. an average 40%) than do the CMHD. In fact, if Miami-Dade County Health Department were excluded from the calculation, with only 3% of its resources coming from city/county sources (because it is in a state-centric system), the other four CMHD realize 49% of their revenue locally from their cities and counties.

[5] NACCHO, "Local Public Health Agency Infrastructure, A Chartbook." Scheduled for release in 2006.

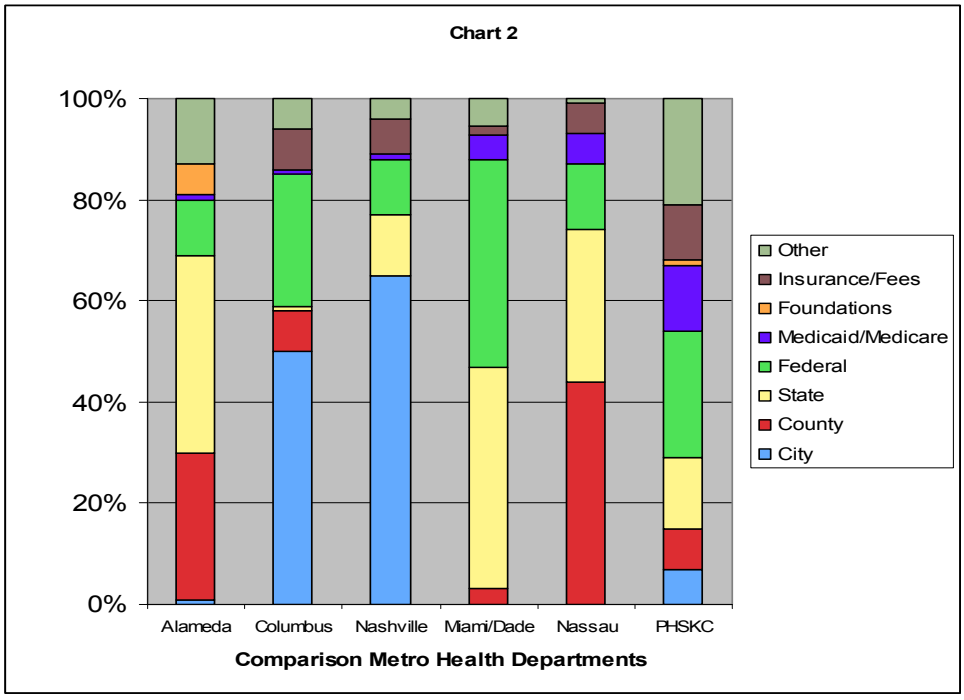
Table 5
Comparative Funding Streams and Total Expenditures
Source: NACCHO Profile Sheets, 2006 (Unpublished)

FUNDING SOURCE	PHSKC	Alameda County, CA	City of Columbus, OH	Miami-Dade County, FL	Nashville-Davidson County, TN	Nassau County, NY
Expenditures (thousands)	$243,794[6]	$99,867	$37,850	$66,090	$42,339	$88,600
Population (thousands)	1,737	1,444	1,069	2,253	570	1,350
Percentage of funding streams						
City sources	7 %	1 %	50 %	0 %	65 %	0%
County sources	8 %[7]	29 %	8 %	3 %	0 %	44%
State sources	14 %	39 %	1 %	44 %	12 %	30%
Fed sources (via State pass-thru)	18 %	0 %	23 %	41 %	6 %	6%
Fed sources (direct)	7 %	11 %	3 %	0 %	5 %	7%
Medicaid/Medicare	13 %	1 %	1 %	5 %	1 %	6%
Private foundations	1 %	6 %	0 %	0 %	0 %	0%
Health insurance/ patient fees	1 %	0 %	2 %	0 %	2 %	2%
Regulatory fees	10 %	0 %	6 %	1 %	5 %	4%
Other	21 %[8]	13 %	6 %	6 %	4 %	1%

- Medicaid/Medicare: PHSKC receives a significant portion of its budget from patient charges to Medicare and Medicaid, with 13% of its revenues budgeted from those sources. As noted earlier, PHSKC also enjoys FQHC status, receiving Medicaid reimbursements for service provided under that designation at rates much closer to actual cost than is the case with other services provided to Medicaid-eligible patients. None of the other CMHD was close to this level of revenue support, demonstrating lower levels of primary care and clinical services. None of the other CMHD have FQHC-designated clinics.

[6] From 2004 Actual Expenditures, all counties. For King County, includes jail health, emergency medical services, and the Public Health Fund actual expenditures.
[7] For PHSKC, county sources does not include Jail Health, CX contribution, even though the 2004 Actual Expenditures do include Jail Health.
[8] PHSKC Other includes: the EMS Voter Approved Levy ($35M or 17%), and miscellaneous revenues.

The same data is included in Chart 2, which also provides more revenue source detail than Table 4[9].

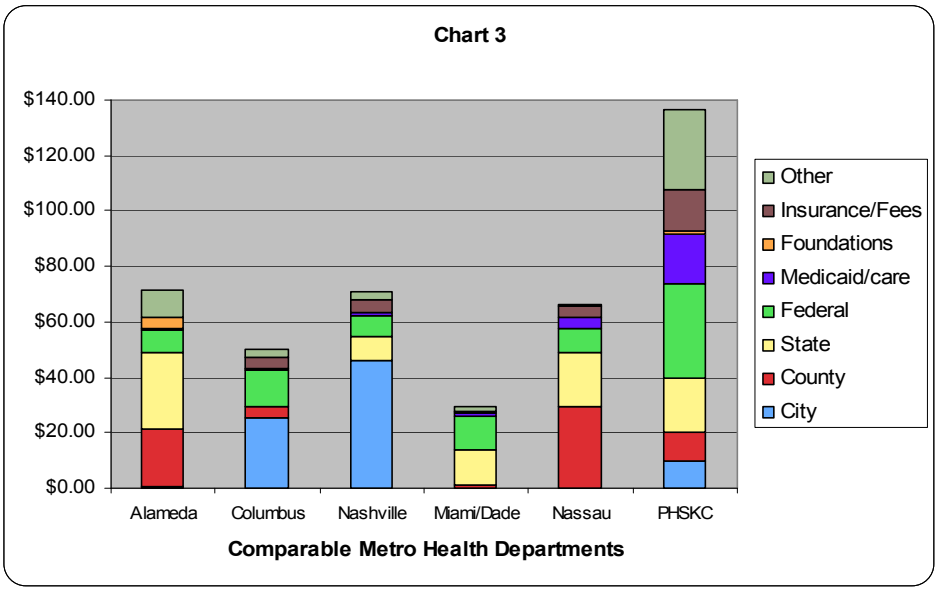


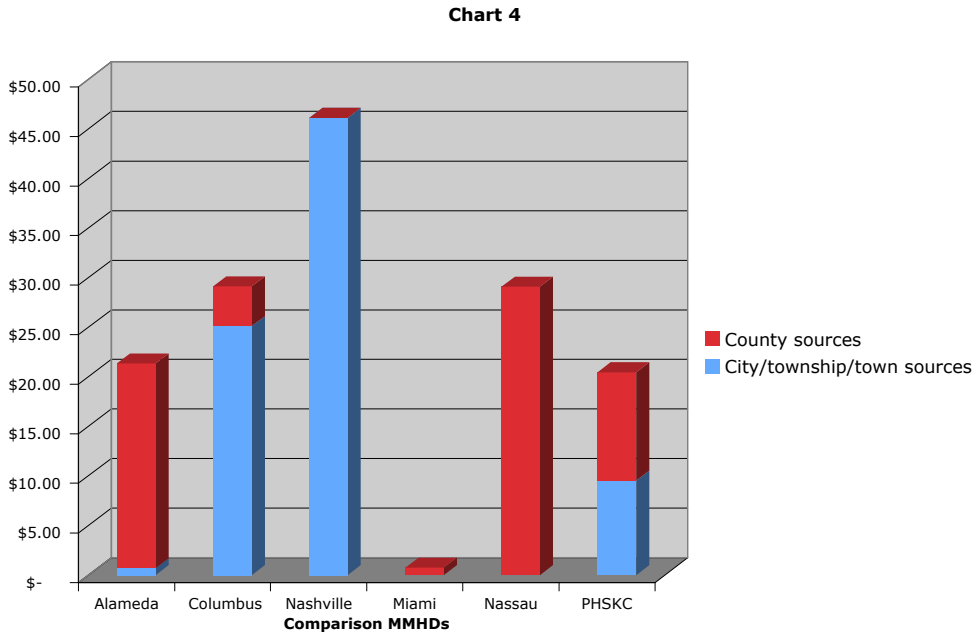
Per Capita Support:

Given the variation in budget size and size of population served among the CMHD and PHSKC, another way to view funding support is by considering per capita support from the various funding streams. PHSKC has been very successful in seeking funding from a wide range of funding sources. As noted earlier, PHSKC receives funding from 251 different sources to support its services and activities. Total per capita support for PHSKC is well above the level for all of the CMHD. PHSKC total per capita funding budgeted for 2006 is over $130, while the average for the five CMHD is $56. Chart 3 on the next page displays per capita support levels by funding source for PHSKC and the 5 CMHD. An examination of the chart shows significantly higher levels of per capita funding received by PHSKC from regulatory fees, Medicaid, & federal funding.

On the other hand, as can be seen in Chart 4, local per capita funding for public health in King County is significantly below three of the CMHD. PHSKC received $20.45 per capita from its county and cities governments, while the average for the four CMHD was $31.42. (Note: Miami-Dade is not included in this calculation as it is in a state-centric system and therefore receives nearly no local money.)

[9] PHSKC Other includes: the EMS Voter Approved Levy ($35M or 17%), and miscellaneous revenues.





Emerging Funding Options

Emerging infectious diseases (e.g. avian flu) and public health issues (e.g. bioterrorism preparedness) have brought with them new revenues. Such has nearly always been the case with the emergence of new issues of public health concern, and there has long been a pattern of "Disease of the Month" funding by Congress. However, new disease- or issue-specific funding by federal agencies do not solve the local health department challenge of finding sources of discretionary funding. Each comes with its own set of

requirements and restrictions. In many instances the funding for new issues is not new money but rather is reprogrammed from existing funds which may impact other current programs.

While the environment is far from replete with new funding streams, there are a few options that might be considered:

- Tax initiatives and special levies: Several health departments, including at least one CMHD interviewed, have benefited from local tax initiatives earmarked for public health. For example, Alameda County residents passed a 0.5% sales tax on all items, with revenues earmarked for a "Health Fund." While 75% of proceeds support indigent medical care, approximately 5% - about $3 million per year – of the revenues are dedicated to the health department as discretionary support.

- Bond issues: Some communities (e.g. DeKalb County, GA) have passed bond issues to support replacement of buildings used by their health departments.

- Modification of existing funding streams: Increased flexibility in permissible uses of funding can be achieved through negotiation with federal and state agencies. In some instances, state health departments add requirements regarding use of federal categorical funds that they pass through to local health departments, well beyond requirements from the federal agencies. The potential exists for negotiation on these added requirements, particularly if multiple health departments collaborate. In California, Assembly Bill 1259 was passed some time ago to increase flexibility in use of public health funding. We understand that the State Department of Health has delayed implementation for reasons that are unknown to locals.

- Collaboration with other organizations: While none of the CMHD had examples where significant new resources had been brought to the table yet, a few felt that there is potential for creating community approaches to address local priorities. One mentioned the need to "make a business case" to local businesses, demonstrating how investment in local health improvement strategies could have a positive effect on the bottom line.

Support for "Core Programs"

While a widely accepted definition of "core public health programs" doesn't exist, the phrase is generally used to reflect programs that are central and critical to the mission of the health department. Nearly all health department

directors would likely agree that communicable disease control is a core public health program, for example. Most others that might be suggested would reflect population level public health programs. In discussions with PHSKC, staff viewed all of their activities with the exception of specifically contracted services to be "core" services, principally because services are defined as core or basic in the joint agreement between King County and the City of Seattle.

Unfortunately, we did not ask the CMHD directors what they consider to be core programs in their respective health departments. From the interviews with directors, however, a number of services, activities and issues were repeatedly emphasized as being of core importance. Those included:

- Social justice
- Health inequities
- Social determinants of health
- Community connections/involvement
- Strategic Planning
- Assessment of communities
- Public health infrastructure
- Health promotion
- Environmental health

Each of the CMHD directors also lamented the scarcity of flexible funding to address these issues. Like PHSKC, many have pursued a number of categorical grants as a strategy to build capacity for assessment and other important population services. Obviously, those with the most local support were able to address issues of core importance more fully than were those with limited local support.

Relative Stability of Funding

All CMHD directors interviewed agreed that it is impossible to project future funding or to rate funding streams with any degree of certainty as to relative stability. Reasons shared include

- Federal funding for public health categorical programs is, with few exceptions, reexamined on a yearly basis. While support levels area relatively stable overall, they vary significantly on a program by program basis each year. In some years, a new initiative of size (e.g. Bioterrorism Preparedness) can result in cost shifting among other categorical programs. Further reductions can be expected in categorical programs over the next few years.

- Revenues from Medicaid are expected to decline in 2006 and beyond because of Congressional budget decisions made in the 2006 session of Congress. While the specific reductions may have limited impact for PHSKC, at least initially, since it appears to impact family planning but not primary care, immunizations, dental or maternal health. However, PHSKC still has the underlying problem of reimbursement rates not keeping up with costs of providing service, and it is expected that the numbers of uninsured will continue to grow in King County.

- While states have experienced difficult budget challenges in recent years, even the expected economic recovery may not benefit public health because of backlogged needs in other areas.

Table 6 summarizes responses from CMHD directors who were asked to rate stability of funding sources. Some offered multiple ratings, noting that several of the general funding streams support a variety of programs that are funded independently of one another and include different levels of risk.

Table 6
Funding Stability Estimates

Funding Stream	Risk of Major Decrease	Risk of Minor Decrease	Stable	Chance-Minor Increase	Chance-Major Increase
Local General Funds	ND	SK,C	A,N	SK,M	
Local licenses and Permits			C	SK,M,N,ND	
Local user fees, insurance and other			A	SK,C,M	
State general fund support	ND	N	SK,A,M		
State categorical grants	ND	SK,C,N	A,M		
Federal grants thru state	SK,C,N	SK	A,M		
Federal direct grants	SK,N	SK,A	C		
Federal/State: Medicaid		SK,C	A,M,N		
Federal: Medicaid Match		SK	A,M,N		
Other:		SK		A	

Key: SK = Seattle-King A= Alameda C = Columbus
M = Miami-Dade N = Nassau ND = Nashville-Davidson

It is interesting to note that the respective directors were most pessimistic about federal and state grants for categorical programs. To the degree that the prognostications are accurate, CMHD that rely most heavily on such grants for general support are likely to experience more significant funding challenges.

This is particularly the case for PHSKC, where local funding comprises a relatively small portion of the overall budget. Staff has indicated that increasingly they are finding it necessary to construct capacities for mission-critical activities such as community assessment through creative use of federal categorical dollars. It is feasible that reduction in that funding stream could threaten basic capacities in the years ahead.

The most optimism was reserved for increasing revenues from licenses, permits and user fees. While potentially helpful, those revenue sources are not very flexible and are not likely to contribute to general capacities that are threatened by other reductions.

The challenges of seeking financial security result in an endless pursuit of resources among all health departments, and particularly for the MMHD around the country. All of the CMHD interviewed acknowledged that finding resources to continues services is a continuing challenge; in the words of one, "there simply is no magic bullet" for funding health departments. Each is facing similar challenges. The director in Alameda County Health Department expressed a unique perspective that real improvement in health status will ultimately require a very different approach than "continuing to scrap for little siloed grants, many of which are of questionable value." He is convinced that the only hope for making significant gains in health status and decreases in health inequities is through full engagement of the community, addressing the social determinants of health. His health department has begun a pilot program in two areas of Alameda County, placing nurses, educators, environmental health specialists and community organizers in the community to help residents address very local issues and to advocate for their needs and interests before elected bodies. Evaluation of the effort is planned, although it is too early to gage results now.

Stability of PHSKC funding:

Overall, fund resource levels have been relatively stable for the past 7 years. Percentage shifts have been minimal and would be viewed as within normal management discretion to make appropriate adjustments. However, there have been significant shifts at the project level, indicating that a great deal of flux has taken place. Funding must be analyzed at a project/program level to make determinations of relative stability or policy implications that have occurred over the years. Given the very large number of programs at PHSKC, we have not analyzed all to consider funding stability of each. However, the following comparison of selected projects illustrates the wide differences that have occurred in the growth rate of funding for specific projects during the 7 year period. Some of the changes reflect organizational change and not necessarily growth or decline.

	2000 $	Adjusted
STD Clinical	-54.9%	-62.5%
PCH Community Programs	-53.0%	-60.3%
STD Prevention	-0.2%	-0.2%
Total Public Health funding	16.1%	18.3%
Epidemiology	27.3%	31.1%
Food Protection	35.6%	40.5%
PH Community Based PCH	41.8%	47.6%
Family Health	46.0%	52.3%
Immunizations	48.5%	55.2%
Family Planning	59.1%	67.3%
PH Interpretation	92.9%	105.7%
Child Care Health	208.4%	237.2%
Access & Outreach	290.3%	330.4%

Deeper analysis would be required to determine the cause of such disparities. Factors might include the level of funding from the funding source, changing prioritization of critical needs, and/or management decisions to direct discretionary funding in different directions. It is also important to note that these changes are based on 2000 dollars; the positive percentages would have increased and negative percentages decreased by approximately 13.8% to adjust for inflation or population size changes("Adjusted" column) .

General Risks to Funding Streams:

There are several very real risks to public health funding streams at the national, state and local levels, both in the intermediate and longer terms. While all may not agree with this listing, it is important to think outside of public health and healthcare to anticipate and prepare for such risks. Most of the areas listed below were mentioned by leaders from the CMHD as having some likelihood of risk.

National level risks:

- Reduction in "federal discretionary[10]" funding due to
    - Continued or expanded military actions
    - Additional or continued tax reductions

[10] Federal discretionary funding refers to funding for all programs that are not mandated. Mandated programs are items such as Medicare, Social Security, debt service, and perhaps the military. Virtually all other programs are considered discretionary in the federal budget, including public health.

    - Significant inflation and/or economic downturns
    - Continued obligation for debt burden with a large budget deficit
    - Medical care inflation, dumping more people out of coverage
    - Concerns regarding social security and Medicare funding
    - Inflation costs not matching revenue increases
    - Medicaid Administrative Match discontinues

- Changes in Congressional make-up and/or the Administration, resulting in new priorities replacing old ones that support public health
    - National health insurance (which could affect public health positively or negatively)

- New federal laws that impact public health services
    - Immigration laws
    - Medicaid changes
    - Additional federal mandates
    - Elimination of federal mandates
    - New service mandates pertaining to emerging diseases and issues

Examples of public health programs and services that could be affected by such reductions or changes could include any of the grant programs (e.g. WIC, Family Planning), emergency preparedness, HIV/AIDS, primary care clinics and general administrative capacity.

<u>State level risks:</u>

- Legislature
    - Continued failure to address core public health funding
    - Initiative for improved access to healthcare (could affect public health positively or negatively)
    - Change in leadership
    - Tax revolt
    - The Basic Health Plan fails or has funding reduced significantly

- Governor
    - Change in leadership
    - Refocus of priorities
    - Replacement of current DOH leadership with ineffectual leader

Examples of services that could be affected by any of the changes at the state level include immunizations, HIV/AIDS prevention, youth tobacco prevention, and foster care.

<u>Local level risks:</u>

- Worsening relationships among units of government
- Economic crisis

- Growth in current budget obligations that exceeds funding growth
- Significant health risks from new or emerging infectious disease, resulting in widespread illness and death
- Annexations and incorporations. Municipal level or type of services with a shrinking regional funding base.

Reductions in city or county support for PHSKC could affect any of the programs supported by county general fund allocations (Appendix 6), the clinics supported by funds from the City of Seattle. Further, reductions in county general fund support could jeopardize federal grants where match is required and provided by such funds.

One can add to or delete from this list, but the point is that there are a number of potential risks to public health funding, and any can occur in the future. Potential outcomes could have a significant impact on public health in general, and on PHSKC in particular. The Department already has a process in place for making programmatic decisions in times of significant budget reductions through the "Proviso Report – Public Health Priorities and Funding Policies 2003." Other CMHD directors have indicated that the best preparation for funding catastrophes include

- having a well organized and operating health department with solid leadership
- having a clear understanding of and dedication to core programs and activities
- keeping the board of health and elected officials fully informed
- being deeply connected with the community
- having collaborative relationship with partners
- maximizing flexible funding streams

One general risk of relying on funding streams that do not support core programs and activities is that of diluting focus and attention on mission and increasing the cost of administration. For example, all the CMHD interviewed no longer provide primary care[11], saying that it both detracted from population services and distracted their vision away from trying to find solutions to the access problems. An additional consideration is that the policy intent with respect to provision of primary care is never clearly articulated. Resolving health coverage issues is not generally considered to fall within the scope of resources available to local government, and the policy changes required to fully assure access are not within the purview of local government. On the

[11] Alameda County public health does not provide primary care, but another department within the County structure does.

other hand, at the very least the health department must have the capacity and expertise to assess access issues and health consequences, and to develop policies which can impact them.

Conclusions

In this concluding section, we provide a summary of our interpretation of the significance and meaning of the observations and findings in this background paper, and their implications for a broad policy framework for decision making about public health in King County. First, the key observations:

- **Funding approaches for PHSKC are fairly typical of CMHD.** While PHSKC has significantly higher per capita funding overall than CMHD, the department is funded in a similar fashion with many of the same sources of funding as the CMHD interviewed.

- **Local funding for PHSKC is low.** Variations in funding of MMHDs are principally related to differences in community and state dynamics. Local general fund support is higher among four of the five CMHD, both as a percent of budget and on a per capita basis.

- **Adequate discretionary funding is essential.** Most of the funding streams, and particularly federal categorical programs, available to local health departments offer limited opportunity to build capacities for services that are core to the mission of public health. Flexible funding sources are of critical importance to assuring capacities to conduct community assessments, perform communicable disease control work, and conduct population-level work designed to improve overall health status.

- **Core capacities have been cobbled together.** In the absence of adequate levels of discretionary funding, virtually all health departments assemble capacities for assessment, community participation, and other core activities from creative use of categorical program funds. Those capacities are continually at risk of funding shifts among the categorical programs.

- **Public health funding is not predictable.** All MMHDs in the country are facing the same challenges with regard to funding. It is not possible to predict with certainty the likelihood for expansion or contraction of existing public health funding streams in the current political environment.

- **Funding opportunities don't have equal merit.** Adding more categorical programs as a capacity building strategy may not really strengthen health department core capacity and may in many instances be a distraction. It can also lead to a dilution of managerial resources needed to support the department's mission.

- **PHSKC has managed well through lean budget times.** However, it is very important to understand that the nearly flat budget over the past 5 or 6 years is taking its toll. Costs increase by perhaps 5% per year while revenues at the macro level have increased less than 3% per year. It will not be possible to maintain services at current levels without new resources.

Important implications for next steps in development of the policy framework based on this description of funding include:

- **Being clear on mission and core responsibilities is essential, particularly in times of uncertain funding.** There is no agreed upon definition of "core" and it is more a term of art subject to various interpretations. In order for the funding challenges of today and tomorrow to be addressed adequately, the core responsibilities need to be defined on a basis of the Departments mission and vision, and should be the basis for programmatic decisions in the future.

- **PHSKC needs higher levels of discretionary funding.** With the relatively large dependence of PHSKC on external funding sources, it should not be a surprise that activities and services are heavily influenced by the Federal and State politics and policy. In order to assure a well functioning and effective local public health system, adequate levels of flexible funding, including in particular adequate local funding, is critically important to creating a public health infrastructure able to protect and improve the health of the community.

- **Stability of external funding for the years ahead are dependent on numerous issues.** While federal and state funding is dependent to a significant degree on the changing make-up and political perspectives of members of the respective legislative bodies, some generalities can be stated and might be considered as implications for future choices and for the policy framework:

    - Federal categorical programs with well-established successes and large, supportive interest groups have fared reasonably well in the

past during economic downturns. Examples include Immunizations, WIC, and probably HIV/AIDS

- Programs with less well-established successes and/or with political "liabilities" are challenged in Congress each year. Examples include health workforce programs, family planning.

- Funding associated with building critical basic infrastructure to assure minimal levels of essential services, for example epidemiology and surveillance, have been tied to categorical programs like Bioterrorism and Pandemic Flu preparedness. The CDC made early attempts to promote "dual use" strategies; however this emphasis has disappeared in recent grant cycles.

- Large programs that have appeared "over night" in recent years are probably at risk of disappearing or going through significant down-sizing. An example is the bioterrorism preparedness program.

- Most stable and subject to the most growth potential at present are funds generated by dedicated tax assessments (e.g. Alameda County; as growth continues, the revenues will continue to grow).

- **Primary care needs are not declining.** Unless a major health access initiative occurs at the state or federal level, health departments providing primary care will continue to see increases in the numbers of un- and under-insured people. Costs will continue to rise, while Medicaid and Medicare reimbursements are declining, at least at present.

- **Innovative approaches should be considered.** Some of the answer to longer term stability may lie in completely reassessing the costs and benefits of the funding streams currently in play for public health. Creating and resourcing innovative ideas such as the approach in Alameda County, CA, should be considered. There, the director believes the only hope for making significant gains in health status and decreases in health inequities is through full engagement of the community, addressing the social determinants of health.

APPENDIX 1
Glossary

- **Categorical funding:** governmental funding, usually from the federal level, which is designed to be used in support of specific public health programs and activities. It typically is accompanied with tight limitations on how the funds can be used, even within programs.
- **Clinical services** are provided to individual clients/patients by any of a variety of health professionals, including physicians, nurses, dentists and others, to address specific health issues, including treatment of illness or injury or prevention of health problems.
- **Comparable metropolitan health department (CMHD)** is a term used specifically for this project and describes one of the five CMHD to which PHSKC was compared. They include the health departments serving Alameda County (CA), City of Columbus (OH), Miami-Dade County (FL), Nashville-Davidson County (TN), and Nassau County (NY).
- **Core Public Health Program:** A public health program or service that is crucial to the central mission of the health department. Such programs include assessment, communicable disease response, and others that contribute to population level prevention, health protection, and health promotion.
- **EPSDT:** A federally funded program for the "Early and Periodic Screening, Diagnosis and Treatment of children.
- **Essential Public Health Services:** established under the aegis of the federal Department of Health and Human Services in 1994, this list of ten sets of services comprises service categories that must be in place in all communities to assure an adequate local public health system.
- **Evidence-based practices:** public health activities which are designed based upon authenticated studies of efficacy and/or upon established practices.
- **Health Status**: The current state of health for a given group or population, using a variety of indices including illness, injury and death rates, and subjective assessments by members of the population.
- **Local public health agency (LPHA)** is a single governmental organization, regardless of size, providing public health services to the residents of a political jurisdiction; also known as a "local health department."
- **Local Public Health System:** in any community, the local governmental public health agency and all organizations, agencies and individuals who, through their collective work, improve or have the potential to improve the conditions in which the community population can be healthy.
- **Major metropolitan health department (MMHD)** is a local public health agency which is one of the 25 largest metropolitan health departments in the U.S.; while the size of the population served by MMHDs is widely variable, most provide services of close to a million or more people.

- **Mandatory:** Programs or activities which are explicitly required by state or local laws or regulations.
- **Match** – Funds or other resources, usually local, which must be applied to a specific program or activity under rules associated with the granting authority for the program or activity. Such resources are not discretionary.
- **Metropolitan health department (MHD)** is a local public health agency that provides services to a political jurisdiction with a population of 350,000 or more.
- **Personal health care**: encompasses the services provided to individual patients by health care providers for the direct benefit of the individual patient. Examples include physical examinations, treatment of infections, family planning services, etc.
- **Population-based public health services** are interventions aimed at promoting health and preventing disease or injury affecting an entire population, including the targeting of risk factors such as environmental factors, tobacco use, poor diet and sedentary lifestyles, and drug/alcohol use.
- **Primary care** constitutes clinical preventive services, first-contact treatment services, and ongoing care for medical conditions commonly encountered by individuals. Primary care is considered "comprehensive" when the primary care health provider assumes responsibility for the overall provision and coordination of medical, behavioral and/or social services addressing a patient's health problems.
- **Recommended –** Programs or activities implied or directed by state or national standards, or commonly understood to be good public health practice. At this point in time both national and state standards are not mandatory and are subject to interpretation.
- **Required** — Programs and particularly program activities related to implied or explicit contractual or grant requirements. Services in "categorical" programs that are not mandatory fall into this category.
- **Social Determinants of Health** – Major factors which are significantly associated with health status, including poverty, employment, education, housing, and racism.

Appendix 2
Ten Essential Services of Public Health

1. *Monitor health status to identify and solve community health problems*: This service includes accurate diagnosis of the community's health status; identification of threats to health and assessment of health service needs; timely collection, analysis, and publication of information on access, utilization, costs, and outcomes of personal health services; attention to the vital statistics and health status of specific-groups that are at higher risk than the total population; and collaboration to manage integrated information systems with private providers and health benefit plans.

2. *Diagnose and investigate health problems and health hazards in the community*: This service includes epidemiologic identification of emerging health threats; public health laboratory capability using modern technology to conduct rapid screening and high volume testing; active infectious disease epidemiology programs; and technical capacity for epidemiologic investigation of disease outbreaks and patterns of chronic disease and injury.

3. *Inform, educate, and empower people about health issues*: This service involves social marketing and targeted media public communication; providing accessible health information resources at community levels; active collaboration with personal health care providers to reinforce health promotion messages and programs; and joint health education programs with schools, churches, and worksites.

4. *Mobilize community partnerships and action to identify and solve health problems*: This service involves convening and facilitating community groups and associations, including those not typically considered to be health-related, in undertaking defined preventive, screening, rehabilitation, and support programs; and skilled coalition-building ability in order to draw upon the full range of potential human and material resources in the cause of community health.

5. *Develop policies and plans that support individual and community health efforts*: This service requires leadership development at all levels of public health; systematic community-level and state-level planning for health improvement in all jurisdictions; development and tracking of measurable health objectives as a part of continuous quality improvement strategies; joint evaluation with the medical health care system to define consistent policy regarding prevention and treatment services; and development of codes, regulations and legislation to guide the practice of public health.

6. *Enforce laws and regulations that protect health and ensure safety*: This service involves full enforcement of sanitary codes, especially in the food industry; full protection of drinking water supplies; enforcement of clean air standards; timely follow-up of hazards, preventable injuries, and exposure-related diseases identified in occupational and community settings; monitoring quality of medical services (e.g. laboratory, nursing homes, and home health care); and timely review of new drug, biologic, and medical device applications.

7. *Link people to needed personal health services and assure the provision of health care when otherwise unavailable*: This service (often referred to as "outreach" or "enabling" services) includes assuring effective entry for socially disadvantaged people into a coordinated system of clinical care; culturally and linguistically appropriate materials and staff to assure linkage to services for special population groups; ongoing "care management"; transportation services; targeted health information to high risk population groups; and technical assistance for effective worksite health promotion/disease prevention programs.

8. *Assure a competent public and personal health care workforce*: This service includes education and training for personnel to meet the needs for public and personal health service; efficient processes for licensure of professionals and certification of facilities with regular verification and inspection follow-up; adoption of continuous quality improvement and life-long learning within all licensure and certification programs; active partnerships with professional training programs to assure community-relevant learning experiences for all students; and continuing education in management and leadership development programs for those charged with administrative/executive roles.

9. *Evaluate effectiveness, accessibility, and quality of personal and population-based health services*: This service calls for ongoing evaluation of health programs, based on analysis of health status and service utilization data, to assess program effectiveness and to provide information necessary for allocating resources and reshaping programs.

10. *Research for new insights and innovative solutions to health problems*: This service includes continuous linkage with appropriate institutions of higher learning and research and an internal capacity to mount timely epidemiologic and economic analyses and conduct needed health services research.[7]

Appendix 3
"The 10 Essential Services in English"

Essential Service Number	Non-Public Health Version
1	What's going on in my community? How healthy are we?
2	Are we ready to respond to health problems or threats in my county? How quickly do we find out about problems? How effective is our response?
3	How well do we keep all segments of our community informed about health issues?
4	How well do we really get people engaged in local health issues?
5	What local policies in both government and the private sector promote health in my community? How effective are we in setting healthy local policies?
6	When we enforce health regulations, are we technically competent, fair, and effective?
7	Are people in my community receiving the medical care they need?
8	Do we have a competent public health staff? How can we be sure that our staff stays current?
9	Are we doing any good? Are we doing things right? Are we doing the right things?
10	Are we discovering and using new ways to get the job done?

Appendix 4
Factors Affecting Strategic Direction of CMHD

Factor/MMHD	PHSKC	Alameda	Columbus	Miami	Nashville	Nassau	Average
Community Needs	5	5	5	5	5	3	4.7
Beliefs re MMHD Role	3	2	5	5	5	3	3.8
Tradition & History	3.5	2	5	5	2.5	3	3.5
Mandates & Contracts	5	2	4	5	4	5	4.2
Incremental Decisions	3	4	4	2	4	4	3.5
Threats & Crises	5	4	5	4	4	4	4.3
New Funding Opportunities	5	4	4	4	4	5	4.3
Politics & Advocacy	4	3	4	4	4	3	3.7
MMHD Leadership	4	5	4	5	5	3	4.3
State vs. Local Responsibility	3	3	3	2	2	5	3.0
Statutory Authority	5	3	2	5	5	5	4.2

Note: The factors were rated by directors of the 6 MMHDs, using a subjective scale of significance, ranging from 1 (low) to 5 (high).

Appendix 5
Federal Direct funds –PHSKC 2006

Grant	Amount (2006)
AIDS Care Contracts	4,813,027
Health Care For Homeless	1,788,442
Perinatal HIV Consortium	1,032,091
Trends In Drug Resistant	255,950
Health Resources Services Admin.	237,830
Women Infants & Children (WIC)	212,428
Access & Outreach	200,000
HRSA – Quality Assurance	187,431
HIV Access	186,425
Clinical Dental Services	150,000
WIC Contracts	124,000
Parent & Child Health Community	89,010
Methamphetamine Labs	75,000
Laboratory	51,828
Education-HIV/Aids	23,203
Clinic-HIV/Aids	10,474
CDC-TB Epidemiology Studies	1,900

Appendix 6
Change in County General Fund Support by Project
2000-2006

Project	2000 Funding	2006 Budget	% Chg
KING COUNTY OVERHEAD	1,756,463	1,913,132	0.0891957
INVESTIGATIONS	1,379,764	1,737,803	25.9%
AUTOPSY EXAMINATIONS	920,740	1,687,703	83.3%
PH COMM BASED PCH SVCS	11,962	1,446,677	11993.9%
PH INTERPRETATION PROGRAM	292,518	1,363,931	366.3%
IMMUNIZATIONS	453,375	1,331,916	193.8%
FAMILY PLANNING	975,436	1,312,410	34.5%
TUBERCULOSIS CONTROL	533,454	1,146,056	114.8%
EPIDEMIOLOGY	601,018	976,115	62.4%
TB OUTREACH-OVERFLOW		853,335	
LABORATORY	660,023	764,758	15.9%
FAMILY HEALTH	338,933	524,908	54.9%
CLINICAL DENTAL SERVICES	-55,709	398,285	-814.9%
HEALTHY AGING	184,854	314,547	70.2%
ACQ IMMUN DEF SYNDROME	128,474	279,871	117.8%
VECTOR/NUISANCE CONTROL	268,740	251,238	-6.5%
CORE COMMUNITY ASSESSMENT	311,409	248,778	-20.1%
EDUCATION-HIV/AIDS	37,886	226,954	499.0%
CHILD CARE HEALTH	161,269	215,632	33.7%
FOOD PROTECTION	536,848	212,196	-60.5%
NEEDLE EXCHANGE		201,483	
INDIGENT REMAINS	158,967	143,233	-9.9%
WASTE WATER DISPOSAL	242,707	140,678	-42.0%
STD-CLINICAL	804,306	139,957	-82.6%
STD-CLINICAL OUTREACH		134,401	
DRINKING WATER PROTECTION	94,106	132,719	41.0%
COMMUNITY CLINICS	1,292,866	101,265	-92.2%
HIV ACCESS	174,758	96,688	-44.7%
STD-PREVENTION		96,498	
AIDS PREV/ED CONTRACTS	109,659	93,418	-14.8%
CLINIC-HIV/AIDS	67,301	83,407	23.9%
ACCESS & OUTREACH	86,974	81,356	-6.5%
PCH COMMUNITY PROGRAMS	-9,691	73,775	-861.3%
CHEMICAL/PHYSICAL HAZARDS	235,917	66,959	-71.6%
AIDS CARE CONTRACTS	218,572	64,376	-70.5%
HIV OUTREACH/INTERVENTION	145,243	44,422	-69.4%
CHILD & FAMILY COMMISSION		37,287	
HEALTH RESOURCES SVC ADM	12,221	29,535	141.7%
HRSA – QA		27,605	
PLANNING COUNCIL-PREVENT	-203	10,935	-5486.7%
WOMEN INFANTS & CHILDREN	341,165	6,517	-98.1%

INJURY PREVENTION	32,121	6,274	-80.5%
CEDAR HILLS-MEDICAL	718,968	0	
FAMILY PLANNING HLTH EDUC	329,280	0	
TEEN HEALTH CENTERS	233,815	0	
HLTH CRE FOR HOMELESS NET	200,253	0	
COMM BASED ORAL HLTH SVCS	129,317	0	
BOARD OF HEALTH	118,162	0	
CHLD PROFILE-HLTH PROMOTE	112,743	0	
HLTH EDUCATION/PROMOTION	97,191	0	
TACOMA SMELTER PLUME	71,134	0	
MATERNAL CARE-OTHER	63,725	0	
LIVING ENVIRONMENT	59,529	0	
BREAST&CERVICAL HLTH PROG	51,892	0	
GERIATRICS	29,561	0	
COMM CLINIC PHARM/PROG SU	26,040	0	
MCH/AIDS CENTER	25,804	0	
SKIL ACTIVITY REGS/DIVS	23,344	0	
SEATTLE ACCESS&OUTREACH	19,327	0	
PFP COUNTY	17,248	0	
ADMIN-REVENUE SUPPORTED	10,471	0	
MOMS PLUS	8,287	0	
FAMILY PLANNING-CSO	7,300	0	
UNDISTRIBUTED ENCUMBR	7,205	0	
HCFA MATCH OVERSIGHT	6,681	0	
KC HEALTH ACTION PLAN	5,140	0	
COORD FAMILY SERVICES	2,815	0	
COMMUNITY CLINICS-SEATTLE	2,794	0	
PLUMBING/GAS PIPING	2,417	0	
SEA-DAY CARE SCREENING	1,572	0	
EH PROGRAM SUPPORT	1,305	0	
PEDIATRICS & TEEN HEALTH	1,095	0	
YOUTH TOBACCO PREVENTION	886	0	
SITE HAZARD-ASSESSMENTS	564	0	
OSS WORKSHOPS	529	0	
TOTAL	15,890,840	19,019,033	19.7%